COMMONWEALTH OF MASSACHUSETTS
HUMAN RESOURCES DIVISION

MEDICAL EXAMINATION FORM
INITIAL-HIRE MEDICAL STANDARDS

This form is to be used for all medical examinations performed pursuant to the Medical and Physical Fitness Standards Regulations for Public Safety Personnel. Communities not subject to these regulations may also use this examination form.

A. Completed by Municipality (type or print in ink)

Name of Examinee (Last, First, Middle)_____

Municipality_____ Social Security #_____ Date of Birth_____

Position: Police Officer_____ Firefighter_____

☐ Initial Exam ☐ Other Exam (Please explain) _____

B. Privacy Notice

The collection of the information on this form is authorized under regulations filed with the Secretary of State of the Commonwealth of Massachusetts. This information will be used to determine the fitness-for-duty of public safety personnel. The information may be disclosed to the Municipal Keeper of the Records; an appropriate government agency for law enforcement purposes; where relevant in a legal or administrative proceeding to which the Commonwealth or a Commonwealth municipality is a party or has interest; to a government agency upon its request when relevant to its decision concerning employment or other benefits; to an expert consultant or other person under contract with the Commonwealth of Massachusetts to fulfill an official agency function including audits of services provided under these Medical Standards; to an investigator, administrative judge, or complaints examiner appointed for the investigation of a formal complaint of employment discrimination; to officials with responsibility for administering workers' compensation, disability retirement, and other benefit entitlements; to an examinee's private treating physician; and to medical personnel retained by the Commonwealth of Massachusetts to provide medical services in connection with an employee's health or physical condition related to employment. Completion of this form is voluntary. If this information is not completed, the examination may be considered incomplete. ***Knowingly providing false or incomplete answers may result in the rescission of a conditional job offer or dismissal if discovered at a later time.***

C. Consent and Certification (Completed by Examinee)

I hereby authorize collection and use of the information on this form for the purposes stated in the above Privacy Notice. I have read and understand the provisions of the Privacy Notice included in this form. I certify that all the information given by me in connection with this examination will be correct and complete to the best of my knowledge and belief.

I also understand that if I fail an initial medical examination, I may undergo a reexamination within 16 weeks of the date of the failure of the initial examination. If I fail to pass the reexamination, my appointment can be rescinded. (M.G.L. Chapter 31, Section 61A.)

Signature of Examinee _____ **Date** _____

It is mandatory that a **signed copy** of this cover page, and a copy of the Medical Verification Section (page 6) be returned by fax (617-727-0399) or mailed to the Human Resources Division (HRD), Organizational Development Group, Room 301, at One Ashburton Place, Boston, MA 02108.

D. General Instructions for Examining Physicians

All health care providers who perform initial hire medical examinations for police officers and fire fighters must read, understand, and apply the current Medical Standards approved by the Human Resources Division (HRD) of the Commonwealth of Massachusetts. The purpose of this examination is to determine if the candidate is medically qualified to perform the essential job functions for the position of police officer or fire fighter. This form is designed to facilitate application of these Medical Standards, but it is not a substitute for the applicable Medical Standards. The Medical Standards for police officers and fire fighters are included in the Physician's Guide, which is distributed by HRD, One Ashburton Place, Boston, MA 02108. Information regarding the application and interpretation of these Medical Standards may be obtained by contacting HRD by telephone at (617) 727-3777 or by fax at (617) 727-0399.

If the cover page, which includes the candidate's Certification and Consent, and Section E, Medical History, are not already completed, the examinee should be advised to complete these sections before the examination begins so that the examiner can review the medical history with the examinee to clarify any incomplete or uncertain information. Any relevant additional information obtained by the examiner must be clearly documented in Section H, the section in which the examiner should provide any additional notes regarding the medical examination.

Each examinee must receive a comprehensive medical examination, which includes all systems necessary to ensure that he or she meets the applicable Medical Standards. This examination should be inclusive of, but not limited to, all items listed under Section F, Medical Examination. Breast, rectal and prostate examinations are required only if clinically indicated. Any abnormal findings should be documented in sufficient detail to support the fitness recommendations of the examiner based upon the history, examination, and test results. A doctor of medicine or osteopathy, a nurse practitioner, or a physician's assistant may perform the examination. If the examination is performed by a nurse practitioner or physician's assistant, a doctor of medicine or osteopathy must review the entire examination file and complete the Medical Verification Section.

All diagnostic and laboratory tests required under the Medical Standards must be performed and documented in Section G, Laboratory and Diagnostic Tests. Any abnormal results should be detailed in Section H, Additional Notes, and copies of the complete test reports attached. Fitness recommendations should be deferred until all test results are received and reviewed by the examining physician.

If the examinee's fitness is uncertain after the examination process is complete, additional information may need to be obtained. The examinee should then be afforded an opportunity to submit medical records or any other relevant information from his or her personal physician or a medical specialist. The examining physician should advise the examinee regarding any information that would be necessary or useful to assess his or her fitness (e.g. the report of an exercise tolerance test performed by a board certified cardiologist). Any costs incurred in obtaining such information are the responsibility of the examinee.

When the examining physician has compiled and reviewed all relevant information regarding the examinee's health, the Medical Verification Section should be sent to the appointing authority (for initial Standards examinations), with a copy to HRD. The Medical Verification Section provides a means of communicating relevant information regarding the examinee's ability to safely and efficiently perform the essential functions of the public safety position based upon the applicable Medical Standards. Detailed medical information should not be disclosed on this form. In the event the examinee fails to pass the examination, only the relevant section of the applicable Medical Standards should be referenced on the form. Medical examination records are the property of the appointing authority. They must be kept accessible for the duration of the examining physician's contract for use in the event of an audit, appeal or disability proceeding. If the contract terminates or expires, the physician will be instructed to transfer these records to his or her successor. The physician, however, may retain copies of his or her examination reports.

The Human Resources Division performs routine audits of examinations performed pursuant to the Medical and Physical Fitness Standards Regulations for Municipal Public Safety Personnel in order to assess the effectiveness of the examination process. Health care professionals under contract to the Human Resources Division periodically review representative samples of examination reports. The consent provided by the examinee on page one authorizes release of copies of this form and supporting documents for this purpose. In the event of an audit, it is possible that the health care provider performing the audit may need to contact the examining health care provider for purposes of clarification. The release provided will permit the examining health care provider to cooperate with the audit process.

Name of Examinee _____ **Social Security Number** _____

E. Medical History (completed by examinee before examination)

INSTRUCTIONS: Please answer all questions accurately and completely. If you do not understand any question, you should request clarification from the examining physician. The information provided regarding your medical history and health habits will be used to make a medical assessment of whether you can safely and efficiently perform the essential functions of a public safety position. Detailed medical information will be treated confidentially. It is essential that you answer all questions accurately and completely. Please note that a history of a health problem will be carefully evaluated and will not necessarily disqualify you from employment.

Do you now have or have you ever had any of the following: (Circle **Y**es or **N**o)

1. Fracture of skull, jaw or facial bones	Y	N
2. Concussion or other injury to head	Y	N
3. Thoracic outlet syndrome	Y	N
4. Fracture of neck, vertebrae or spine	Y	N
5. Recurrent back or neck pain	Y	N
6. Degenerated or herniated disc	Y	N
7. Back injury or other abnormality	Y	N
8. Back, spine or neck surgery	Y	N
9. Osteoporosis	Y	N
10. Arthritis or joint injury or disease	Y	N
11. Amputation involving hand or foot	Y	N
12. Carpal tunnel syndrome	Y	N
13. Other hand or wrist problems	Y	N
14. Dislocation of any joint	Y	N
15. Injury or abnormality of arms or legs	Y	N
16. Need for corrective lenses	Y	N
17. Deficiency of color vision	Y	N
18. Disease of the eyes or sinuses	Y	N
19. Loss of hearing	Y	N
20. Exposure to loud noise	Y	N
21. Disease of the ear or vertigo	Y	N
22. Deformity of mouth or jaw	Y	N
23. Speech impediment or disorder	Y	N
24. Tuberculosis	Y	N
25. Pneumothorax or collapsed lung	Y	N
26. Bronchitis, asthma or other lung disease	Y	N
27. Abnormal electrocardiogram (EKG)	Y	N
28. Heart disease or cardiac abnormality	Y	N
29. Irregular heart rhythm	Y	N
30. Angina/chest pain/shortness of breath	Y	N
31. Hypertension/high blood pressure	Y	N
32. Organ transplant	Y	N
33. Liver, pancreas or gall bladder disease	Y	N
34. Ulcer or bowel disease	Y	N
35. Intestinal bleeding	Y	N
36. Hernia of any type	Y	N
37. Kidney or bladder disease	Y	N
38. Abnormal balance or coordination	Y	N
39. Fainting, blackouts or dizzy spells	Y	N

Please explain "yes" answers by referencing item number. Provide (in the section to the right of each #) pertinent information relative to diagnosis and treatment for each "yes" response. Include dates for injuries, illnesses and follow up treatments. Please use the back of this page if necessary.

38. Abnormal balance or coordination	Y	N
39. Fainting, blackouts or dizzy spells	Y	N
40. Stroke, aneurysm or bleeding in head	Y	N
41.Multiple sclerosis or muscular dystrophy	Y	N
42. Myesthenia gravis or ALS	Y	N
43. Epilepsy or seizures	Y	N
44. Dementia or memory loss	Y	N
45. Migraines or other severe headaches	Y	N
46. Paralysis or muscle weakness	Y	N
47. Other neurological disorders	Y	N
48. Eczema or other skin disease	Y	N
49. Skin grafts	Y	N
50. Bleeding disorder/anticoagulation treatment	Y	N
51. Sickle cell disease or trait	Y	N
52. Blood clots or thrombosis	Y	N
53. High or low blood cell counts	Y	N
54. Enlarged or ruptured spleen	Y	N
55. Diabetes or high blood sugar	Y	N
56. Thyroid or other endocrine disorder	Y	N
57. Cancer, malignancy or tumor	Y	N
58. Mental or emotional disorder	Y	N
59. Mental health treatment of any type	Y	N
60. Lupus, scleroderma, dermatomyositis	Y	N
61. Heat stroke, frostbite or burns	Y	N
62. AIDS, HIV infection or hepatitis	Y	N
63. Any history of alcohol or drug abuse	Y	N
64. Current use of any prescribed drug	Y	N
65. Allergies or chemical sensitivities	Y	N
66. Occupational (work) injuries	Y	N
67. Disability or compensation claim	Y	N
68. Asbestos or toxic chemical exposures	Y	N
69. Required light or restricted duty	Y	N
70. Military rejection or medical discharge	Y	N
71. Medical treatment in past 12 months	Y	N
72. CAT Scan, MRI or other special tests	Y	N
73. Smoked cigarettes or tobacco products	Y	N
74. Are you pregnant?	Y	N
75. Other health conditions requiring treatment	Y	N

#___ _____
#___ _____
#___ _____
#___ _____
#___ _____

Are you currently receiving any disability benefits? Y N

Name of Examinee _____ **Social Security Number** _____

F. Medical Examination

INSTRUCTIONS: After reviewing the Medical History provided in Section E, conduct a comprehensive examination of all systems necessary to determine the examinee's fitness under the applicable public safety position Medical Standards. The examination should include, but not be limited to, the areas listed below. If the examinee has conditions relevant to a fitness determination which are not listed below, the examiner is responsible for documenting all such conditions.

Height _____ **Weight** _____ **Blood Pressure** ____/____ **Temperature** _____ **Pulse** _____

Vision Testing	**Without Corrective Lenses**			**With Corrective Lenses**		
Distant	**Rt. 20/___**	**Lt. 20/___**	**Both 20/___**	**Rt. 20/___**	**Lt. 20/___**	**Both 20/___**
Near	**Rt. 20/___**	**Lt. 20/___**	**Both 20/___**	**Rt. 20/___**	**Lt. 20/___**	**Both 20/___**

Visual Fields (degrees) **Right: Temporal____ Nasal____** **Left: Temporal____ Nasal____**

Color Vision **Ishihara: ____Normal ____Abnormal** **Yarn or Lantern test: ____Passed ____Failed**

EXAMINATION	**Normal**	**Abnormal (Identify by number and explain if abnormal)**
1. Skin	_____	_____
2. Head, face and scalp	_____	_____
3. Ears, tympanic membranes	_____	_____
4. Eyes, pupils, fundi, motion	_____	_____
5. Nose, sinuses, olfaction	_____	_____
6. Mouth, throat, speech	_____	_____
7. Neck, thyroid	_____	_____
8. Heart	_____	_____
9. Varicosities, bruits, pulses	_____	_____
10. Chest, lungs	_____	_____
11. Breasts (if indicated)	_____	_____
12. Abdomen, hernia	_____	_____
13. Rectum (if indicated)	_____	_____
14. Endocrine	_____	_____
15. Spinal mobility, alignment	_____	_____
16. Upper extremities, hands	_____	_____
17. Lower extremities, feet	_____	_____
18. Muscle strength, tone	_____	_____
19. Gait, Rhomberg	_____	_____
20. Balance, coordination	_____	_____
21. Reflexes	_____	_____
22. Cranial Nerves	_____	_____
23. Mental Status	_____	_____

Signature of examining health care provider _____ **Date** _____

Print name of examining health care provider _____ **MD DO NP PAC (circle one)**

Name of Examinee_____ **Social Security Number** _____

G. Laboratory and Diagnostic Tests

INSTRUCTIONS: Three diagnostic tests are **required** under the Medical Standards. Although not specifically required under the Medical Standards, additional tests may be performed. Some tests **may be required** by the appointing authority or approved by the appointing authority to further evaluate conditions detected on the medical history form and/or during the physical examination. For each test performed indicate below whether the results were **normal** or **abnormal** and document any abnormal results in Section H. **Copies of all laboratory reports should be attached to this form as part of the permanent record**.

REQUIRED TESTS:		**RESULTS**	
A.	Pulmonary Function Test	____Normal	____Abnormal
B.	Audiogram	____Normal	____Abnormal
C.	A Purified Protein Derivative (PPD) Test for tuberculosis	____Negative	____Positive

OTHER TESTS:		**RESULTS**				
D.	Urine Dipstick	___Normal	___Abnormal	___ Sp. Gravity	___ Protein	___ Sugar
E.	CBC	___Normal	___Abnormal			
F.	Chemistry panel	___Normal	___Abnormal			
G.	Urine drug screen	___Negative	___Positive			
H.	Electrocardiogram	___Normal	___Abnormal			
I.	Chest X-Ray	___Normal	___Abnormal			
J.	Hepatitis B Immunization	Dates of Immunizations: #1_____	#2_____	#3_____		
K.	Tetanus Immunization	Dates of Immunizations: _____				
L.	Other	_____				

_____

H. Additional Notes

INSTRUCTIONS: Use this section to summarize any additional medical history information, abnormal physical examination findings, abnormal diagnostic or laboratory test results, and any other relevant information obtained during your evaluation. Please note that sufficient information must be documented so that your decision-making process is clear to any reviewer in the event that the examinee appeals an adverse fitness determination.

In the event that an examinee does not pass the examination, please document in the Medical Verification Section whether **each** disqualifying condition represents a Category A or Category B condition, as defined in the Medical Standards. If Category B, please explain below why you determined that the examinee's condition precluded his or her safe and efficient performance of one or more of the essential functions of the public safety position. Additional pages (i.e. transcription notes) may be attached to this form.

_____
_____
_____
_____
_____
_____
_____

Signature of examining health care provider _____ **Date** _____

Printed name of examining health care provider_____ **Date** _____

I. Medical Verification Section

INSTRUCTIONS: Review the medical history, physical examination documentation, diagnostic test results, and laboratory reports in relation to the applicable public safety position Medical Standards and make a determination (regarding) whether the examinee meets all requirements of the Medical Standards. Conditions classified under Category A in the Medical Standards preclude an examinee from work in the public safety position. Conditions listed under Category B in the Medical Standards require careful individual consideration and may require further evaluation to determine whether the condition would preclude this individual from safely and efficiently performing the essential functions of the public safety position. If there is uncertainty regarding an examinee's health status or functional abilities which could be resolved with additional information, the examinee should be offered the opportunity to provide medical records, reports from medical specialists, or any other relevant information in order to determine passed or failed status. In this case, the examinee should be advised by the examining physician as to what information is needed for follow up. He or she should be provided with a reasonable, but specific amount of time during which to provide the reports to the examining physician, who will thereafter advise the municipality of the status of the examinee.

If an examinee fails an initial medical examination, he or she is eligible to undergo a reexamination within 16 weeks of the date of the failure of the initial examination. If the examinee opts for a reexamination, he or she must arrange it with the municipal authority.

NOTE: In cases where the medical examination has been performed by a nurse practitioner or physician's assistant, a doctor of medicine or osteopathy must sign this Medical Verification Section.

When all necessary information has been received and reviewed, complete this Medical Verification Section and distribute per instructions below. Medical examination records are the property of the municipal authority. They must be kept accessible for the duration of the examining physician's contract for use in the event of an audit, appeal or disability proceeding. If the contract terminates or expires, the physician will be instructed to transfer these records to his or her successor. The physician, however, may retain copies of his or her own examination reports and selected materials.

Name of Physician _____

Address of Physician _____**Telephone** _____

Municipality _____ **Fire Department** ____ **Police Department** ____

PHYSICIAN'S CERTIFICATION OF FITNESS

I have reviewed the medical examination for the following examinee using the Human Resources Division's Medical Standards Program for Public Safety Personnel:

☐ Initial Exam ☐ Other Exam (Please explain) _____

Name of Examinee: _____ **Social Security #:** _____

Home Address: _____

Home Telephone: _____ **Date of Examination:** _____

Physician must check one of the following and sign below:

I hereby certify that the above named examinee _____ passed OR _____ failed the medical examination.

_____ I have noted below the specific section(s) of the Medical Standards that were not met:

Section _____ _____ Category A _____ Category B
Section _____ _____ Category A _____ Category B
Section _____ _____ Category A _____ Category B

PHYSICIAN'S NOTICE OF EXAMINEE'S FAILURE TO PROVIDE COMPLETE & ACCURATE MEDICAL HISTORY (See Privacy Notice on Page 1 of this form and please provide comments below and attach documents if necessary.)

_____

_____

Physician Signature: _____Date: _____License #_____

Print Physician Name: _____ MD DO (circle one)

The Medical Verification Section must be returned to the Appointing Authority. The Appointing Authority will forward the Medical Verification Section, along with a signed copy of page one of this Medical Examination Form to the Human Resources Division (HRD). These Sections may be faxed to (617) 727-0399, or mailed to the Commonwealth of Massachusetts, Human Resources Division, Organizational Development Group, One Ashburton Place, Room 301, Boston, MA 02108.